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ABSTRACT

Educational, psychological and mental health, and medical computer databases were searched, and three occupational reference texts were examined, in an effort to identify the position of the child development specialist (CDS). Other objectives were to initiate a dialogue in the profession and among those who might value services of CDSs, and to invite reader response and participation in the search for a professional identity. This review focused on job description, training, skills, credentials, and work settings. The review found that confusion about the professional identity and the role of the CDS, whose functions include child care worker, administrator, policymaker, and researcher, is widespread among members of other professions and the public, as well as among practitioners themselves. The teamwork of the CDSs emerged as their most significant secondary role in child care work. The research documents the pioneer status of the position, as well as the professional isolation and identity crisis reported by practitioners. The literature offers recommendations concerning legislation, training, credentials, and curriculum. The findings from this review are consistent with a model developed earlier in which a range of training, titles, affiliations, and functions among CDSs is viewed on a continuum of experience and education. A figure appended to the review depicts this continuum. Also appended is a list of 72 reference works. (BC)

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The Child Development Specialist:

In Search of a Professional Identity

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Abstract

Research stored in educational, psychological/mental health and medical bibliographic retrieval systems, and information available through occupational and guidance systems, on the position of child development specialist, is reviewed with a focus on job description, training, skills, credentials and work settings. Emphasis is placed on profiling theoretical perspectives and the different ways child development specialists contribute to the helping professions through developmental assessment, counseling, advocacy, consultation and education functions. Limited research and career information document the pioneer status of the position, professional isolation and identity crisis reported by practitioners. Recommendations include: (a) a core curriculum at undergraduate and graduate level; (b) continuing education and experience over time, toward professional maturity; (c) identification of a network for credentialing, promotion of quality assurance standards, professional benefits and position advocacy; (d) increased coordination and communication among specialists who work with children birth through adulthood; (e) increased research; and (f) increased articulation and dissemination of career information.

The Child Development Specialist: In Search of a Professional Identity

During the 20 years of training and experience in which this educator became a child development specialist, I frequently felt, and through research and communications came to know, that other child development specialists felt the need to define the position in an effort to increase general knowledge about what we do and how we do it. Confusion about the role of child development specialist is widespread among members of other professions and the public, as well as among practitioners, ourselves. At the same time, it will be acknowledged by most professionals, that child development specialists have provided valuable services, historically, in a variety of settings and circumstances crossing discipline and institution.

It is this transdisciplinary characteristic of the child development specialist position that constitutes its strength at the same time it contributes to the "no man's [person's] land" perception of a role which, for the most part, is uncredentialed in its own right. Professional identity, standards and quality assurance depend on the umbrella of a work setting, leaving child development specialists without an independent professional support network and basic benefits, including an acknowledged license to practice and a mechanism for professional advancement represented by the recognition of continuing education and achievement available to comparable professionals through licensure. Absence of a uniform credential contributes not only to the aforementioned confused status of the profession but to isolation of practitioners, one from another, to questionable credibility (especially important in child

protective court work) and to economic discrimination as a result of the lack of third party payment qualification.

The purpose of this study is to identify the position of child development specialist (CDS) as it exists internationally, to initiate a dialogue within the profession as well as among others who value or might come to value services of CDSs and to invite reader response and participation in this search for a professional identity.

Overview of the Research/Literature

To accomplish the above purposes, a computer search of the ERIC, PSYC, NCMH and MESH data bases from 1966 to September, 1982 was conducted. In addition, The Dictionary of Occupational Titles (1977), The Occupational Outlook Handbook (1980-81) and the Computer Guidance Information System (1982) were consulted for definition, four year college, and graduate level characteristics for the position of child development specialist. The ERIC search yielded 44 citations; PSYC, 7; NCMH, 15 and MESH, 2. Discounting duplicates, a total of 59 citations were reviewed. A synthesis of that material follows. Several applicable references from subsequent work by this author are included.

The Thesaurus of ERIC Descriptors (1982) defines child development specialists as "persons whose professional training has prepared them to understand and work with the changes that take place in children as they develop from birth to maturity. These specialists may work with other professionals, paraprofessionals or parents as well as with children" (p.34).

Although this definition seems straightforward enough, what literature exists suggests there is no such simple, commonly held concept of the position. Consider the following general terms included as CDSs in the ERIC typology: child developmentalist, child behavior consultant (CBC), and child development associate (CDA). Clarification of these terms is necessary to the improvement of communication about the professional identity of those known as child development specialists.

As described in the literature, a child developmentalist is a doctoral level specialist in mental health whose key function is to screen children three to six for behavioral, learning and suspected organic problems, and to participate on a community-based multi-disciplinary team to advocate for the developmental needs of those children as related to mental health issues (Cook, N., 1976).

A child behavior consultant (CBC) as described by Reger (1969) is an educator chosen by administrators from among the teaching ranks, trained informally and released from teaching duties to work with children, their parents and school staff. Although the term "child development" was used with "child behavior" in the introductory line of Reger's report, it was not used again in the 89 pages describing the position. Neither was traditional child development language used in the narrative of the CBCs' functions, the project's overall goals, or the extent to which those goals were met. The language used to list the "wide range of student types" referred for CBC services, (e.g., "deviances" and "abnormalities") (p.85) indicates a perspective quite

different from the child-centered, growth-task orientation of the CDS. Both students and staff reported perceptions of CBCs' roles as tutorial (p.49), disciplinarian (p.51), and behavior modifier (p.53). The CBCs, themselves, reported that the major percentage of their work consisted of tutoring, followed by behavior modification and consultation with teachers, parents and administrators. One of the eight CBCs in this project reported a small percentage of time spent on crisis intervention, resource and experimental functions, group guidance, teaching demonstrations and teaching (p.73). Two did not think their role entailed a different type of interpersonal relationship with the students than that of their previous role as teacher. The other six thought the CBC role was less formal, more intimate, involved less emotion on their part, was more objective, was more empathetic, or gave them more time with students than did the role of teacher (p.82).

Pierce-Jones and others (1968) reported a different role for the child behavior consultant in elementary schools, developed in a research and demonstration project, the goal of which was to provide effective services to "help insure for every child . . . maximum opportunity for a successful school experience and . . . serve the cause of prevention, in children, of hampering mental health disturbance" (p.3). The use of CBCs was proposed as an alternative to direct service to children by providing mental health consultation to school people. "The goal of child behavior consultation, where the school is concerned, is to modify the perceptiveness of school personnel, especially elementary school teachers, and thereby enhance their abilities to work effectively with all chidren" (p. 5). The term CBC was selected "after careful

consideration of the possible adverse effect of the designation Mental Health Consultants or other terms possessing mental health connotations" (p. 24). In addition, the position was developed in response to the "virtual lack of experienced school consultants" and the fact that "what few school consultants there were would require financial remuneration far beyond the budgetary possibilities of the project" (p. 24). Use of third and fourth year graduate students in Educational Psychology or Psychology as CBCs provided consultants with some experience in psychotherapy or counseling who were trained to enter into a peer relationship with the consultee (school staff) in which the two "traded knowledge" (p. 26). The problem was viewed through the eyes of the consultee and the goal was "competent coping" (p. 26). It was reported that 15 CBCs were utilized in 14 experimental schools in the two year period.

In both of these projects, emphasis seemed to be on meeting the personnel, administrative and fiscal needs of the school systems rather than on assessing and facilitating the overall development of children in regard to school adjustment and progress, which is the traditional role of the practicing child development specialist in a consultation and educational position: teaching others how to assess and program for developmental factors.

The child development associate (CDA) is a two year credential developed by Project Head Start to provide a training opportunity for those affiliated with their programs who want to move up the "career ladder" (Career Planning and Progression for a Child Development Center, 1973). Emphasis in training is on early childhood education and application of theory to the

various functions entailed in working with children and their families through federally funded child development programs. Although the position is not of a specialist level, except to the extent that the CDA majors in child development related training opportunities and practices in child development settings, this credential is an exciting example of a profession creating and honoring a career development option from within the ranks, which has gained widespread respect as an entry-level associate degree since the announcement of the new profession in 1971 (Zigler). For a more detailed discussion of CDA competencies, functions, training and evaluation models, the reader should consult the Child Development Associate Training Guide (1973), and work by Biber (1973) Galler (1981), Klein (1973), and Williams and Krohnfeldt (1973).

Additional investigation further establishes the confusion surrounding the professional identity of the child development specialist at the same time it contributes to an appreciation of the unusual versatility and value CDSs are demonstrating at many professional levels. Work by Beavers and Kidler (1974), Daumrind (1973), The Day Care and Child Development Council of America, Inc., (1969), and Mazyck (1971), all of which is categorized under the child development specialist descriptor, refers to training and job performance from general entry level child care workers, through foster and houseparents; nursery school and day care aides, teachers and directors; including the broad category of preschool and early childhood educators, to doctoral level, widely known experts on child development in the fields of health, education and human services. Included are studies by Eckerson (1969), Eckerson and Smith

(1968), Murphy (1970) and Rawlyk (1977) which categorize elementary school guidance counselors and elementary specialists in physical education (American Association for Health, Physical Education and Recreation, 1973; and Johnson, 1980) as child development specialists.

In their work, Guerney (1972) and Sheiman (1979) call psychologists and psychiatrists child development specialists. Examples of roles performed by CDSs in medical settings include social worker (Comfort and Kappy, 1974); child and family counselor (Little Red-Filmhouse, 1979; Mesibov, Schroeder and Wesson, 1977); and instructor to medical students on developmental assessment and parent interview techniques (Shuman and Gross, 1978). CDSs were noted as being especially contributory to projects on parental stress and child protection (Adkins and Ainsa, 1978; Duffield, 1976; and Mohite, 1979; Ranzoni, 1984); foster parent training (Gross, Shuman and Magid, 1978; and Guerney, 1977); and as primary therapists/counselors and developmental tutors on school and center based teams in both standard and therapeutic programs (Bauman,1976; Dickel, 1978; Eckerson and Smith, 1968; Fairbanks, 1976; Johnson,1980; Lewis, 1978; Murphy, 1970; Rawlyk, 1977; Seidman, 1970; and Smith, 1968).

Although the article, "A Pediatric Counseling Service" (Klein, 1982) was not cited in the computer search, nor does it refer to a CDS per se, it is highly indicative of the traditional CDS approach to an innovative service. The language of the piece, itself, is immediately recognizable as child development theory and practice. In its description of the importance of project staff knowing expected developmental stages and being able to convey

age-appropriate expectations to parents and significant others, this article is classically child development in perspective and, as such, represents the philosophy and modus operandi of the CDS.

The multi-faceted functions of the CDS, then, as profiled in this survey of the literature includes: (1) child care worker; (2) teacher; (3) administrator; (4) supervisor; (5) consultant--to toy manufacturers (Sheiman, 1979), to a public library (Smardo, 1978), to the media (Winston, 1970); (6) advocate; (7) social and public policy maker; (8) researcher; (9) individual and group direct service provider to children and families as counselor, assessor and social worker.

The role of advocacy and the advisability of expanding the input of CDSs to public policy and decision making regarding children and families is treated by Kerckhoff (1980), Kilmer (1970), Hertz and Dennis (1978), and Takanishi (1981).

It should be noted that in the literature, as well as in theory and practice, children and families are linked inseparably with important implications for interdisciplinary training, practice and research. Endsley and Brody (1981) especially, identified the need for increased interaction and communication among child and family professionals who tend to separate themselves through professional networks and specialized communications.

The teaming or interfacing aspect of the work of the CDS emerged from the literature review as the most significant secondary role (or means of accomplishing the primary role of supporting the child) in institutional and

child care work (Artis, 1974); on counseling teams--including telephone "warm lines" (Adkins, 1978); --with pediatricians, child welfare and juvenile court workers, psychologists, psychiatrists and social workers (Benswanger, 1978; Cook, N., 1976; Duffield, 1976; Endsley and Brody, 1981; Johnson, 1980; Mohite, 1979; and Ranzoni, 1984).

Because teaming is a fact of life for the CDS, both the inexperienced and experienced practitioner will find reassurance in the literature for recognizing and dealing with conflict resulting from differences in theoretical perspective when teaming on behalf of a child regarding assessment, treatment, program and placement decisions (Hyman, et al, 1973; and Abidin, 1975). The most commonly reported differences in perspective occur between those of the bahavioral engineering and humanistic philosophies (Morris and Pai, 1976).

Basic issues deteriorate easily to personality conflicts when stakes are high and resources limited, both of which seem to be true more times than not when the quality of life for children and families is in question. Professional isolation, in combination with such differences in theoetical position can, over a period of time, be discouraging for the CDS whose voice can get lost along with the child's in the politics of other, longer established professional power bases (Ranzoni, 1986). Wise supervisors who value the contributions of CDSs will provide much needed support in this area.

If one thinks of each teaming effort as a mini-coalition on behalf of a child, a temporary alliance of distinct parties for joint action, we can more easily see how conflict can arise. Because the concept of coalescing is relatively new and requires special skills which are just beginning to be

learned, observable and predictable barriers exist: professional insecurity, fusion of professional identity with organizational goals, turf guarding and professional exclusiveness (Jones, 1978). In "Coalitions: Is The Price Right?" Jones suggests the following principles and strategies: (a) agreement on the goals of advocacy that require strong and broadbased support, (b) commitment to the concept that controversy, when responsibly handled, can be enlightening, (c) commitment to the skills of negotiation and compromise, (d) trust that a variety of disciplines, services and interest groups can work together without endangering the rights of others.

Happily, the literature contains a message of encouragement, limited as it is. We are certainly in a pioneering phase as a profession, yet we can proudly point to progress and the unique services we are being asked to provide which focus on strengths and growth rather then dysfunction and/or physical or mental illness. Regardless of label or diagnosis, we can assess developmental status and make common-sense, pragmatic recommendations to facilitate continued development. These skills cross discipline, department and diagnosis.

> In summary, the child developmentalist adds the dimensions of developmental sequence to both the assessment data and the treatment plans, adds an understanding of the importance of the context in which the child develops, identifies critical points in parent-child and child-environment interaction patterns and facilitates the liaison with the educational setting. In relation to the parent, the child developmentalist identifies for the parent, the parent's potency or ability to change the

> developmental outcome of their children by identifying specific behavioral patterns which the parent as well as anyone else would have difficulty handling. The child developmentalist lends a knowledge base which expands the understanding of child and checks simplistic interpretations of the data and thereby balances the assessment results and the reality of the child's behavioral patterns. The child developmentalist's contributions are maximized in an interdisciplinary setting where the unique frame of reference can balance a simplistic, uni-dimensional assessment with a transactional model and where the child development perspectives can be expanded to include the significant considerations of other disciplines. (Cook, N., p. 9, 10)

In contrast to some service delivery models that tend to dehumanize a child, reducing him or her to a case number, the CDS can validate a child's uniqueness through use of developmental assessment. The CDS can formulate expectations and encouragement for individual growth regardless of disability or discouragement. The child developmentalist, or child development specialist, believes in possibilities rather than limitations.

> The child developmentalist characteristically brings a more comprehensive integration of developmental sequences when he views a child as well as the parent. The significance of this reliance on developmental sequences becomes more obvious as management plans are designed. First,

> the identification of a carefully sequenced series of behaviors provides a framework for conveying realistic expectations to the parent, rather than announcing only a diagnostic term. This is true regardless of the developmental age of the child. The treatment plan shifts in some cases from the shock of how delayed the parent's child is, to what can we as parents do which will optimize our child's development. It shifts from obliteration of the future for their developmentally disabled child to what can we as parents expect to see emerging in our child's behavior. (Cook, N., p.4)

In the same way, I have observed the developmental approach to assessing and recommending/prescribing for children to be less threatening to parents when difficult and delicate issues are a concern, especially the question of maltreatment. When extended through a program based on child development theory and practice, the positive perspective is magnified, as exemplified by the staff of CDSs who are primary therapists at the therapeutic nursery school at the Chicago-Read Child Development Center, Chicago-Read Mental Health Center, about whom it has been written:

> . . . the program has always been permeated with an attitude of hope and expectation. The question is never whether a child can be helped but, rather, how and in what way . . . . at the core of the treatment

process is the hope, confidence and investment . . .

that is manifested by the whole staff. (Baumann, p. 179)

Itkin (1967) has suggested that legislation similar to the Gibbons Bill in Illinois for the training of child development specialists be adopted as a model to improve the training of school psychologists. Likewise, Constance Cook (1971) has described the successes of the New York legislation regarding state programs utilizing CDSs. Fairbanks (1976) has described the Oregon model in which CDSs, as members of public school district staffs, are key to prevention, early identification and intervention. An overview and update of the Oregon model, including its development, conceptual basis, goals and objectives, accomplishments and results of a ten year longitudinal evaluation can be found in the April, 1984 issue of the Personnel and Guidance Journal. (Sheldon and Morgan)

Several of the studies reported comparisons of perceptions and perspectives between CDSs and others: lawyers (Kerckhoff, 1980), child care administrators and paraprofessionals (Mazyck, 1971), low-income and Head Start parents (Lewis, 1978), and elementary public school (kindergarten to second grade) teachers (A Study of Early Elementary Teacher Evaluation of Selected Eye-Hand Coordination skills of Kindergarten Children, 1969).

In all cases, the standards of the CDS were reported to reflect knowledge and skills consistent with the accumulated body of knowledge on human development and was characterized by child advocacy, a child-centered position. As indicated earlier, these are considered prerequisite attributes of the professional who would be called a child development specialist.

Whereas the theories and methods of Piaget (Case, 1872, and Elkind, 1972) and Montessori (Adams, 1969, 1970) were cited, literature on child development training models and methodologies was meager. Since this search was conducted, the author has had a training model specific to the identification and resolution of childhood sexual abuse accepted by ERIC for inclusion in its data bank (Ranzoni, 1985). Dusewicz's Knowledge of Infant Development Scale to test the effectiveness of pre and inservice training was the only piece found, specific to evaluation of the CDS (1973).

In spite of the conspicuous absence of references to traditional and recently evolved child development models of programs and practice, the literature is replete with significant implications for training the CDS, most of which will correspond generally to job performance and role expectations. Without exception, the reports cited the need for interdisciplinary training, praxis and research. Innes (1981) suggests practica team experiences in child care, mental health, hospitals and public schools for the CDS-in-training, in order to provide first hand knowledge of the variety of roles "which involve working with significant adults and systems that influence the lives of young children" (p. 271).

Specific function-related training for CDSs was reported by Manthe for homebased intervention (1973); by Boss and Gregg for the care and rehabilitation of children with mental retardation (1966); by Smith for developmental delays and educational problems constituting learning disabilities (1968); The Day Care and Child Development Council of America, Inc. for administrative

roles (1969); and Bauman for urban and rural collaboration in training, especially the importance of knowing the demographic characteristics of the work site (1976)--also recommended by Manthe.

It is assumed that the CDS would meet the credential standards of role-specific positions, described in the literature as a minimum of masters degree in counseling for the CDS as elementary school counselor, and special education certification for schoolbased work with children with specialized needs.

There is agreement that knowledge of child development theory and practice, family dynamics and parent education models, as well as of the significant settings in which children live and work (home, school, community) are fundamental to a core curriculum with emphasis on communications, counseling, assessment, prescribing and programming competencies.

Further recommendations include knowledge of child protective laws, child and family rights (Kerchhoff, 1980); social and public policy and decision making participatory skills (Feshback, 1982; Kilmer, 1979; and Takanishi, 1981); training in research skills, at least at the consumer level and at the contributor level for the expert (Hertz and Dennis, 1978; Ranzoni, Note 1).

Nancy Cook spells out the importance of the degree and quality of education required to establish the credibility of the CDS (1976); and Takanishi emphasizes the importance of a professional emphasis (1981) in concert with Feshback (1981); Endsley and Brody--as a way to decrease professional isolation (1981); Hertz and Dennis (1978)--on the important place of research in achieving professionalism; Benswanger, et al (1978) on the evolution of the new professional role of CDSs; and Comfort and Kappy (1974) on interprofessional relationships.

Also conspicuous by its absence is reference to the specialist in adolescent development. Having had the benefit of working with an adolescent CDS in the children's services unit of a community mental health center, I found his training, skills, functions and approaches to assessment and treatment to be comparable to mine as an early and middle childhood specialist. Through disposition meetings and program management activities in which we coordinated the child and adolescent teams, I came to value highly the continuity and extended perspectives we could lend through reciprocal consultation and mutual support. Such collaboration was especially important in cases of advanced or delayed development which often occur during the uneven growth of late middle childhood and early adolescence or late childhood. In addition, we reminded each other and other staff of the importance of seeing beyond one's own specialities and client populations to the whole life span.

It is essential that we continue to educate both professionals and the public that child development is a discipline concerned with the full range of growth from birth to adulthood and that within that range are specialists in infant, early and middle childhood, as well as adolescent development. Greater attention to the language we use with ourselves and others to define these areas of foci will contribute to a greater understanding of who we are and what we do. It is no longer true that child development, the term given to emerging early childhood pre-public school programs, refers solely to those programs or people. We can help get the message out by calling for more specificity in the language, by increased research, definition and dissemination of our work.

Given the foregoing historical review, it is no less than astonishing that the position of child development specialist is not listed in the latest editions of the Dictionary of Occupational Titles (1977), The Occupational Outlook Handbook (1984-85), nor is it included yet in the computer Guidance Information System. Where, then, do we search for a professional identity? Among ourselves!

Summary

Findings from this literature review are consistent with a model I have developed illustrating the various functions of the child development specialist's work (Ranzoni, Note 2). The developmental needs of the child/client/student/patient are at the hub of a wheel of activity, given momentum by the operationalization of these supportive functions which are seen as spokes, and which are both independent and interdependent. The whole is given structure by a rim of standards of (a) the profession, (b) the practice site, (c) the referring party, and (d) the community. The function categories, which reflect my experience and research, are: (a) developmental assessment, (b) developmental counseling, (c) collateral interfacing/teaming, both as a team member and leader with administrative and supervisory responsibilities), (d) consultation and education, (e) research and resource development and dissemination, (f) the specialist's own professional development and personal growth.

Further, it can be seen that a range of training, title, affiliation and function exists among child development specialists, generically, that can be viewed on a continuum (see Figure 1) of both experience and education, using the ERIC definition, without denying the value of either.

Insert Figure 1 about here

The continuum is designed to show that professional maturity for the child development specialist entails the opportunity to attain expert status through achievement of both horizontal and heirarchical training and practice. The categories of functional levels are illustrated as steps to indicate this possibility (i.e., that a practitioner may become an expert practitioner and need not leave practice to achieve specialist, expert or professional consultant/ contributor status). Research and practice have shown that both patterns of professional development are typical in the field (Sheldon and Morgan, 1984). And rightly so.

There is nothing more inspiring in any profession than the practitioner who, through testing, defining and refining methodologies, comes to model the highest that that profession has to offer. Further, it takes much different skills to be expert in working with children and families than to do expert research. Both skill areas are essential to the healthy advancement of our profession.

Horizontal and vertical representation of skills acquisition is not intended to imply a value judgment but to illustrate the possibility and potential of both, especially for teaming expertise in practice and research. The profession can only benefit from such alliances, just as it will be diminished without them. It should be noted further that advancement of continuing education and experience over time represents typical, though not absolute, patterns of

professional maturation for the child development specialist.

Finally, a word about what it has been like to seek, through this search and re-search, to know and be in touch with colleagues across the country. From my first scan of the printout I felt a growing sense of pride for who we are and what we do. That pride has increased with my enthusiasm through the long hours of work in which my professional identity has been enriched measurably. Whatever else comes from this effort, I have been professionally strengthened. Beyond that, it is my hope that the lessons I have learned will be shared and that readers will respond by sending job descriptions from those known as child development specialists, as well as information about resources found to be helpful in defining and promoting the position. I will compile information received in a follow-up paper to add to the data bank.

Meanwhile, please consider this challenge with me:

> Professional orientation is characterized by technical competence acquired through long training; adherence to a set of professional norms that includes a service ideal, objectivity, impersonality, and impartiality; a colleague-oriented reference group; autonomy in professional decision-making; and self-imposed control based upon knowledge and standards. (Hay and Miskel, p.70)

Through this work I join my colleagues, known and unknown, in committing to the challenges of our growing profession, believing that it is only through our knowledge of, and commitment to, one another that we can have a professional identity.

Reference Notes

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Figure 1:
Continuum of Experience and Education
Leading to
Child Development Specialist Status

FUNCTIONAL LEVEL	ASSOCIATE	GENERALIST	SPECIALIST	EXPERT
ROLE	trained volunteer, advanced student, paraprofessional, aide, assistant, associate	child care worker, teacher, administrator, human services worker, social worker, medical worker, mental health worker	assessor, counselor, consultant with emphasis on infant, early, middle childhood or adolescence (theoretical perspective & methodologies defined)	researcher, writer, consultant, practitioner (philosophical perspective refined)
STAGE OF PROFESSIONAL MATURITY	**STUDENT** of the profession, its body of knowledge and standards	**PRACTITIONER** of the profession, its body of knowledge and standards	**CONTRIBUTOR** to the profession, its body of knowledge and standards	
CONTINUING EDUCATION	introductory credential	4 yr. degree or comparable training in related field	masters degree or comparable training in related field	doctorate, advanced study or comparable experience
TIME	entry level to 2 yrs.	5 yrs.	10 yrs.	15 yrs.

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